ORTHOPAEDIC ASSOCIATES
of Wisconsin
There is a Difference.

Dr. Stefanczyk Medical History Form

Name: _____ Today's Date: _____

Age:_____ Dominant Hand □ R or □ L Height: _____ Weight: _____

Chief Complaint: (Why are you here today? For example: "Left knee pain")

_____

Did the problem result from a specific injury? □ No □ Yes, Date of injury: _____

Is this a work related injury? □ No □ Yes, Date of injury: _____

Occupation: _____ Has the injury been reported? □ No □ Yes

Medical History: (Please check previous or current medical conditions)

Are you pregnant? □ Yes □ No □ Possibly

□ None	□ Anemia	□ Gout	□ Metal Allergy
	□ Arthritis	□ Heart Disease/CAD	□ Osteoporosis
	□ Asthma	□ Hepatitis	□ Prostate
	□ Blood Clots/DVT	□ High Blood Pressure	□ Psoriasis
	□ Cancer	□ High Cholesterol	□ Stomach Ulcer/Reflux
	□ COPD/Lung Disease	□ HIV	□ Stroke/Seizures
	□ Depression	□ Irregular Heartbeat	□ Thyroid Disease
	□ Diabetes	□ Liver Disease	□ Vascular Disease

□ Other: _____

Surgical History: (Please list previous surgeries/operations and dates)

□ None _____ _____ _____

_____ _____ _____

Current Medications: (Please list names of all drugs and the doses you are taking)

□ None _____ _____ _____

_____ _____ _____

Allergies to Medications

□ None □ Yes, which drug? _____

What reaction? _____

Social History:

Marital Status: □ Single □ Married □ Divorced □ Widowed

Do you smoke? □ No □ Yes _____packs/day for _____ years

Do you drink alcohol? □ No □ Rare □ Social □ Daily

Family History of Medical Conditions: (Please list any medical problems that run in your family)

□ None _____

Review of Systems: Are you ***currently*** experiencing any of the following symptoms? (Please check all that apply)

No	Yes					
□	□	**General**:	□ Fatigue	□ Weight gain/loss	□ Fever/Chills	□ Insomnia
□	□	**HEENT:**	□ Vision change	□ Hearing loss	□ Sinus pain	□ Sore throat
□	□	**Cardiovascular**	□ Chest pain	□ Palpitations	□ Edema	□ Poor circulation
□	□	**Respiratory**	□ Cough	□ Short of breath	□ Wheezing	□ Pneumonia
□	□	**Gastrointestinal**	□ Nausea/vomiting	□ Indigestion	□ Acid reflux	□ Stomach pain
□	□	**Genitourinary**:	□ Frequent urination	□ Difficult to urinate	□ Painful to urinate	□ Bloody urine
□	□	**Skin**	□ Rash	□ Hives	□ Sensitive skin	□ Easy scarring
□	□	**Neurological**	□ Headache	□ Dizziness	□ Seizures	□ Tremor
□	□	**Psychiatric**	□ Depression	□ Anxiety	□ Mood swings	□ Stress
□	□	**Endocrine**	□ Hypoglycemia	□ Diabetes	□ Thyroid	□ Hot Flashes
□	□	**Hematological**	□ Easy bruising	□ Easy bleeding	□ Anemia	□ Blood clots
□	□	**Immunologic**	□ Seasonal allergies	□ Food Allergies	□ Frequent infection	□ HIV

Patient Signature:_____ Date:_____